Help your practice stand out by recognizing what makes it unique in the marketplace.

“The doctor is board certified.” This is the answer I hear most often when I ask a new practice manager what makes her practice unique or special. While being board certified is an important credential that potential patients are wise to verify and value, there are thousands of board certified plastic surgeons and dermatologists nationwide, so it’s not that “unique.” In fact, in some urban areas it’s common to have 12 or more board certified aesthetic specialists in a three-block radius—and five or more in the same high-rise building. So, let’s back up a minute and take a look at the meaning of the word unique. Merriam-Webster’s Dictionary defines it as “being the only one” and “being without a like or equal.”

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Avoid These Five Reasons that Front-Desk Collections Fail

Karen Zupko, President

Avoid These Five Reasons that Front-Desk Collections Fail
Healio ⋅ Orthopedics Today – October 2017
by Karen Zupko, President

With the number of patients who have high-deductible health plans that are climbing even higher, many practices are moving toward an up-front, point-of-service collections model. Our firm has advocated this for decades. When front-desk collections are implemented correctly, we see significant increases in daily revenue and a reduction in accounts receivable of more than 90 days old.

However, when implementation is not executed well, we find that the initiative often fails, and staff returns to collecting copays and telling patients they’ll be billed after insurance pays.

Here are five common reasons for front-desk collection failure, and how to avoid them:

1. Vague rules, no procedures
The amount to collect varies by payor and patient type, benefit level and service provided. If you don’t provide staff with granular rules about what to collect from each type of patient, don’t be surprised if they don’t ask for payment at all.

Create clear rules and procedures. First, define the amount collected and how it varies whether a patient is covered by a contracted plan vs. Medicare vs. out of network vs. uninsured vs. has a high-deductible health plan. All the amounts in these situations could be different.

Six Steps for Conducting an Internal Evaluation & Management Audit

Sarah Wiskerchen, MBA, CPC

Six Steps for Conducting an Internal Evaluation & Management Audit
Healio Orthopedics • Orthopedics Today – September 2017
by Sarah Wiskerchen, MBA, CPC
Evaluation and management coding patterns are under the microscope. CMS is monitoring evaluation and management code usage by specialty, state and nationally. The Recovery Audit Program of CMS aims to identify and correct improper Medicare payments through the detection and collection of overpayments. Commercial payers are using analytics to identify potentially inaccurate coding, too; take-backs may result.

An annual review of each provider’s evaluation and management (E/M) code usage is essential to effectively manage the audit risk of your practice. The process of reviewing documentation identifies coding pattern or usage anomalies – possible non-compliance. This, in turn, uncovers opportunities for educating physicians and staff on how to properly document, code and bill for services according to federal, state and payer guidelines.

Work RVU compensation formulas and surgery modifiers: To discount RVUs or not

Sarah
Wiskerchen, MBA, CPC

Work RVU compensation formulas and surgery modifiers: To discount RVUs or not
Orthopedics Today – September 2017
by Sarah Wiskerchen, MBA, CPC

In hospital employment settings, as well as large groups, work relative value unit-based compensation agreements and formulas are often standard. Understanding how work relative value units are credited is an essential element of creating or negotiating relative value unit-based compensation. Our firm has found there is no single method applied within physician organizations that use relative value unit-based compensation. This article explains why some work relative value unit reductions make sense and others should be carefully addressed with administrators.

Since 1992, many physician organizations have used work relative value units (RVUs) as a methodology for physician productivity and as an element of their physician compensation formulas. Work RVUs are published annually as part of the Resource-Based Relative Value Scale (RBRVS) developed by the CMS.

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Is Telemedicine the Future of Healthcare?
EDITOR’S NOTE: National Quality Forum (NQF) issued two new reports this week that provide guidance to advance health information technology, with the intent of making healthcare more effective and safer for all Americans.

The terms “telemedicine” and “telehealth” have been used interchangeably in healthcare, but there is a difference. Telemedicine is considered the clinical application of technology, while telehealth encompasses a broader, consumer-facing approach – “a collection of means or methods, not a specific clinical service, to enhance care delivery and education,” according to the federal network of telehealth resource centers.

Telehealth is not a new concept. In 1925, Hugo Gernsback developed a concept for a teledactyl, a tool that used robot-like fingers along with radio technology to examine a patient from a distance via a video feed. Unfortunately, this tool was never actually produced, but rather predicted as a future path
For medicine.

According to the American Telemedicine Association (ATA), telehealth has four primary benefits:

1. Improves patient access
2. Reduces cost
3. Improves quality and safety
4. Improves patient satisfaction

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**Telehealth at a Tipping Point**

Telehealth at a Tipping Point – September 2017
By: Betty A. Hovey, CCS-P, CPC, CPMA, CPCD, and Cheryl Toth, MBA

What’s a service orthopaedic practices can offer that is popular with patients, reimbursed by most payers, not too expensive to implement, and deliverable in all 50 states?

Telehealth: Although it’s obviously not suitable for every type of patient encounter, the value telehealth confers to patients, practices, and payers has pushed adoption to the tipping point. These services also allow practices to differentiate themselves.

**Why consider telehealth?**

According to the American Telemedicine Association (ATA), telehealth has four primary benefits, as follows:

1. Improved access
2. Reduced costs
3. Improved quality/safety
4. Improved patient satisfaction

Indeed, a 2015 Harris Poll found that 64 percent of patients were willing to participate in telehealth visits because of convenience. The ATA says more than 15 million Americans received at least some medical care remotely in 2015, and it expects those numbers to grow by 30 percent in 2017.

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Betty A. Hovey

Cheryl Toth
Top 10 HIPAA Mistakes for Practices to Avoid

Top 10 HIPAA Mistakes for Practices to Avoid – September 2017
By: Michael R. Marks, MD, MBA, and Michael Sacopulos, JD

The Health Insurance Portability and Accountability (HIPAA) Act of 1996 continues to challenge every medical practitioner. A recent discussion on the current state of HIPAA revealed the top 10 mistakes that practices make during implementation.

This year has been rough in terms of privacy. The Office of Civil Rights (OCR) has consistently levied stiff financial penalties on those who violate HIPAA rules. Hacking and ransomware attacks are more frequently in the news. If the confidentiality of patient medical records is not to become a quaint idea of a bygone age, practices need to be proactive. The following mistakes can be avoided, putting your practice on the way to patient privacy protection and HIPAA compliance.

No. 10: Failure to have Business Associate Agreements in place
A Business Associate is a person or entity to whom you provide patient information. These may include third-party billing companies and the service that shreds old documents. Most practices have many Business Associates. The OCR has a free online Business Associate Agreement template that can easily be downloaded.

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Six Steps Ways to Build the Practice ‘Brain Bank’

1. Develop a new employee orientation/onboarding program.
Go beyond the completion of human resources paperwork. An orientation/onboarding program provides new employees with a broad understanding of your organization’s vision, culture and overall practice operations. An effective orientation plan includes items such as:

- a welcome lunch with a small group of staff and at least one physician;
- meeting with the manager to get an overview of current and planned projects;
- meeting with the managing partner to learn about mission, vision and goals of the practice;

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Documentation Guidelines for Medical Decision Making

Margaret Maley, BSN, MS

Documentation Guidelines for Medical Decision Making – August 2017
by Margaret M. Maley, BSN, MS

With a brief history of their development
Thousands of pages of regulation have been generated since the American Medical Association (AMA) first introduced Evaluation and Management (E/M) codes to describe inpatient and outpatient visits in 1992. When originally published, the E/M code descriptors were ambiguous and unclear, resulting in the reporting of erroneous levels of service and the inability to audit or oversee the delivery of services to Medicare beneficiaries.

In 1995, the Centers for Medicare & Medicaid Services (CMS) revised the E/M guidelines to include more specific details about the patient history and the extent of the physical examination. That same year, the AMA and the Health Care Financing Administration (now CMS) introduced their collaboration on the development of E/M documentation guidelines. The AMA emphasized that guidelines were created for the following reasons:

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Got a Good Governance Agreement? Use This 12-Point Checklist to Find Out

Karen Zupko,
A governance agreement is a written directive for how a practice’s board of directors is comprised and how it operates. Governance is the way in which an organization polices itself, and a good agreement includes a number of things that allow your practice to do that effectively. Decision-making policies, meeting procedures and board role definitions are a few examples.